Leaving the system for ethical practice

You partner with people that are your mentors. You surround yourself with the people who are the experts in the things that you are weak at. Right? If I'm the stupidest one in a room, then I am in right room.

Yeah, yeah. How many people have said that? And I actually, I think in business where you're doing something that is totally foreign to you or very fairly foreign, that surrounding yourself that know what you need to know is the way to go.

You didn't build your clinic to feel like an employee in your own business. I'm Matthew Kalogli, and on Out of the System, hosted by Doctor Talks, we challenge the broken rules holding healthcare entrepreneurs back.

Hear from clinic owners, rebels and builders who are creating bold, profitable patient center practices and doing it their way. Hi, Tammy. Hi Matt. How are you?

I'm doing very well. It's great to have you here. Thank you so much. I am looking forward to this conversation. I left December of 2015, but kind of put up the shingle officially in 2018. That's like old school early days of the Regen orthobiologic space, isn't it?

I mean, it wasn't Wild Wild West then, Maybe just the West. Little fringe. Why'd you leave the system? Your anesthesia pain, right? Yeah. Okay. And so what caused you to leave?

I simply could not practice ethically in the kind of practice that I wanted to. I knew that my patients were not getting the care that they deserved, and it was a no-brainer for me.

But you left, but you didn't have your practice to go to right away. What did you do? Anesthesia. You just did Locum's work. No. It was technically, I guess, locums, although I was hooked up locally.

I did not have to travel for locum, but all the while was gaining the skills, gaining this science, getting the clinical construct and how I put together a business.

And so that I knew that when I came back in, it'd be on my terms and to the benefit of my patients. Was that hard to do? Was it hard leave the system?

Not at all. Really? Because a lot of people are like, they get that security, I mean, paycheck. I was dying inside. Were you? Tell me about it. I was with a very large ortho group and I solo without a PA or an NP and in that realm it's volume, volume volume.

You talk about this every day. And typically the other guys that were in the practice were being fed procedures by their PA, or their NP, and they'd spend two, two and a half days a week in a procedure suite and that's where the practices made money.

If you don't have that generating, and they were taking care of the prescription refills and everything but maybe the new patient consults and driving needles.

It wasn't hard to leave when I knew that I was spending an extra four or five hours a night documenting, because thorough, if it wasn' t said, it was' n't done.

If it's not documented, i t wasn t done, and I just, I wasn'' t practicing reflexive or defensive medicine. It was, this is what they told me. This is really is happening and here's my thought process.

Here's where we're going to go with this. one through five of where I want to help this patient. And I actually, frankly, got told, if you don't pick up the pace, you owe us money.

It was a no-brainer to say, then I'm out. I've got anesthesia to go back to, and I will do this right when I come back. Wow. You know, obviously, a lot of conferences we're at and you hear these stories all the time.

When a doctor who was in your situation and they come to you and are like, I don't know if I should really do this or how do I do? What's your advice to them about going out on their own?

Oh, it is what's-your-why. Why do you want to leave? Is it just that you're tired of being the chart monkey? is it tired to being a needle jockey? Or are you literally being sucked dry in your soul?

If you have a really strong why, then the answer is there. So you go back to them and you ask them what is that they miss about why they went into medicine in the first place?

What is is you miss really connecting to patients and really seeing them thrive based on your engagement with them and your partnership with. So it's people end up answering that themselves.

It's not that they're just they need to hop practices or get a nanny or do whatever it is that may help them. I think they need to look at why they went into medicine in the first place.

What are they missing? And then you say, well, if that's really what you're missing, there are so many people out there that have done it. There's so may ways that you can engage in a group of your peers.

and masterminds and conferences and just being in like-minded groups that will get you through it. This is not 100% you on a life raft in the middle of the Indian Ocean.

That's the thing that I think a lot of people miss is that there's a group of people already doing this. One of the things I have found, and you know me, I've worked in a lot of different industries, the medical industry really is unbelievably encouraging, which is interesting because the whole training is to build a silo.

Be the smartest, be the best, at the expense of others, right? But then you see these doctors that come out of the system, and it's almost like they realize how badly they were abused, right?

And then they're like, come on, I'll show you some things. Like, let me help you along. Did you have people showing you the way other physicians taking you and showing, or were you figuring this out on your own?

A lot of it was a figure out on your own at that phase. Now there are people who have done their, you know, the direct primary care, DPC. There's a DSSC, direct specialty care and there's entire groups in Facebook and on LinkedIn or through SoMeDocs, I think you've met Donna Coryell.

And there are just so many people that are there now. At the time, there really weren't, and there were a lot of eyebrows. I'm like, why would you do that?

And what are you thinking? How are going to do? But I just gutted it out in a way that you fail, but you learn the most from the failures. You just keep learning, it keeps getting easier and easier.

What were some of the biggest challenges for you when you went out on your own? I think not having had business training. Yeah. Not having the experience with here's how you market, here is how don't spend marketing money.

Here's where you… That one, don' t spend money is the bigger one. It is a big one! I knew from the beginning that I was not gonna go down the path where I mortgaged the second mortgage or big business loan.

It was going to be bootstrapped and it was gonna be stay as lean and mean as possible. And I'm still running lean

to mean and I think that that was one of the very best victories I've had is remaining lean.

How big of a facility do you have? How many square feet? How many offices? One 20 by 20. Yeah. It's it. Really small room, but it's a larger center. Me and my practice within.

So there's the, the associated services or collaborations right there. so I don't have to be the one with the three or five or seven year lease. Right.

So you're with inside of a unit, right? And do they have all the other tools that you need like fluoro or things like that? No, that is separate. And I have a colleague who's in traditional pain that has a suite that's not always being used.

We've talked about the days that it is most available and I plan ahead. I bring my own fluorotech and have that facility, which is fantastic. Then I just pack up everything in the car and we turn it into a surgical suite and then we break it down and go back to the office.

That's a really good point that for people to understand is we'll meet people. I had a call this morning, somebody who was starting up. Okay, I got to get I'm looking at like 2500 square feet and I gotta outfit it.

And then, you know, the computers and all the machines and da da, da and like, and this is this was more BHRT, functional medicine. So they were looking, oh, i gotta get red light laser and i got Please don't.

Time out. Go sublet space at a med spa. They're like, what? And I go, seriously, I have orthopedic surgeons that set up region practices on Saturdays in med spas.

Sublet, space, and med spots. And they're doing ultrasound guidance, right? They are not doing back, they are doing knees, shoulders, hips, simple stuff.

Right? Simple stuff Sorry, everybody who does, knees, shoulders, and hips. They're not simple. No, I know they're simple, but after a while they are. And we have clients that are like $50,000 a month just subletting space, like, oh, i don't need all this stuff.

Building a lean regenerative clinic

You've kept it unbelievably lean. Very lean and that's been remarkably, you're agile that way, your flexible. If something happens with the sub-let, fine.

You're fine. My ultrasound is on wheels. I have a case, I put it in and I wheel it. PRP machine on the wheels? Centrifuge, yep. Absolutely. What about when you're doing, when harvesting bone marrow?

That's in the spine suite. Okay. Because it's fluoroguided, but the PRT and because I use every bit of what I harvest in terms of the bone-marrow plasma into the ligaments and the muscles and whole thing in this systems approach functional spinal unit, the ultrasound's there too.

Yeah, that's great. All right, so I want to go way back. Way back? Way, way, back! At what age did you know you wanted to be a doctor? So I either want be veterinarian or I wanna be physician at age nine.

Really? Yeah. That might be the youngest I've had. Most people say 12 to 13. Now the vet thing I get, because isn't every girl want to be a vet, like before they're 10, that's kind of like the standard thing, right?

I know my daughter wanted to a be vet until she was like 11 or so. It was because that was the year that I started 4-H. Ah, okay. We lived on what I would call a mini farm.

It's all of an acre and a half, but we still had chickens and sheep and rabbits and dogs and cats and the pigs were across the way at our neighbor's house.

And then the beef paddle was with my uncle on more land in Bend, Oregon. So you could start 4-H in the fourth grade. That's when I'd take my market lamb.

from birth you're responsible for the shearing and the worming and vaccinations and all these things expense-wise, but your market lamb then sold on the fair on that Saturday market.

And as a kid, you know, four or five dollars a pound on a hundred pound lamb as fourth-grader, I knew that that was a way that then I could buy my first car, my bikes, college, anything I needed, I was self-sufficient for.

So that's where the veterinary piece came in. But also I love that part of the animal husbandry of we would help deliver the lambs. We would take care of them.

If there was a baby that was an orphan, then we'd bottle feed it, a bummer lamb. And similarly, we did that with some cows. At what point did you side between medical school?

position or being a vet? It came down to college and Willamette University as a small private liberal arts college in Salem, Oregon versus Oregon State University, a very large system in Corvallis, which had a direct program with UW and veterinary.

And I got just as many scholarships, actually better. It would cost me the same amount of money to go to a state school on scholarship as it would to the private small liberal arts college and I fit into that.

Yeah, I would see you doing better in a small, liberal art school. That would be better for you. I do, rather than a number. it's just my personality and i thrived at Willamette and was pre-med all the way.

Wow. Okay. So walk me through that journey because I find this one I found it fascinating to I'm always curious like, what was that experience like for you?

Residency can be challenging, especially in anesthesia, pain. What was that like for you? Was it difficult? Did some people find medical school a breeze?

Other people found it really difficult emotionally. I was at a small school, Kirksville College of Osteopathic Medicine in Kirkesville, Missouri. We were only there for two years because it was such a smaller town that then we knew we would be farmed out to these regional places for our clinical rotations.

That was Phoenix for me. So the first two being in that small environment, whereas in the Mecca of osteopath medicine was fantastic. I thrived. colleagues who are still colleagues to this day.

I was on a health professional scholarship, so I didn't worry about money. My first year, I financed the second, third, and fourth years were 100% on scholarship which meant that I would owe three years to the Navy once I back.

So for me, it was fine. And then moving to Phoenix got me closer to Oregon. And I fell in love with the desert. So that again was amazing. I was meant to be in the dessert and fall in with hiking and everything that, you know, these beautiful red rocks have to offer.

I guess, good for my soul, those small groups, the small, intimate, get to know your instructors, gets to your classmates, it was fine. And I knew that I would then become active duty after that.

That was in the Navy's hands at that point. I did an internship in Spokane, Washington, and I actually was initially in love with emergency medicine. I could see that for you.

Because you're the same every day, right? Nothing rattles you from my experiences. So I liked that, until I was getting spit upon and cursed out and I'm just trying to help you do that.

You're spitting at me as I try to sew a lac on your forehead and then I am done with that so I thought, well, I really

like the procedures. I like doing things.

it derm and another level that complex rotational flaps and the beautiful plastic closures and maybe even plastic surgery with reconstruction, not the plastics plastics, but the reconstruction and helping rebuild somebody after they've had a devastating thing.

And then Fallujah, then 9-11. I'm like, how am I going to serve my brothers and sisters when I am popping zits, right? So it really was set in stone for me.

I would go to Walter Reed National Naval Medical Center at the time that we were receiving three large plane loads of wounded warriors a week. If you weren't a burn patient who'd go on to Brooke in San Antonio, then you came to us.

And that's 24 to 48 hours after you had sustained your injury, you may have gone to launch stool for an initial surgery, a washout, and then you came to us.

And from there, it was, I mean, go. It was acute pain, acute, pain. Acute pain was managing that pain service. Taking these guys and girls back to the OR every other day for wash out of their multiple amputations.

I was in my element because I helping and it really means so much to me. it fulfills me to know that what I'm doing makes a difference. Yeah. When did it move for you from service to the patient, helping your fellow humans, to at what point did you realize that the system was completely and totally effed up?

It was after I got out. So after you left the military. Because when you're military, you can still get what needs to be done. You don't do prior authorizations, You may have to say, well, we're going to have put you on limited duty for this period of time because this is going take a little bit longer.

And I know you are in a critical mission billet right now. But there weren't those constraints. You'd think on the other hand that, but you're, yes sir, take it up the chain of command, do all these things, and you are getting told no or stay in your place.

But I didn't really find it that way. I was seeing it, that I could get exactly what my patients needed. And they were getting what they needed, The military trained me.

They knew they were going to send me to Japan right after residency. So, I did extra pain at Hopkins, extra at Mayo, and extra in Wazirid National Naval so I could open pain clinics in Okinawa and in Rota, Spain.

I was already practicing pain management before the fellowship. And that's when I started to see a little constraint, but even at Stanford, there's not a lot.

We were very well funded. Patients had maybe seen a dozen other pain clinics at that time that they'd come to us. And we had good resources and we have a fantastic holistic approach.

You're a brand new patient. You see me for an hour. you see our physical therapist for a hour, you our pain psychologist for hour then all of us go to a noon conference and talk about what would be the best holistic integrative approach to your care.

And then we meet back with you and say, here's what we'd like to do. How does that sound? That's fascinating. I never even knew that that I never knew that you did all that, that extensive work.

And how long did you do that? How long were you doing that kind of work? So fellowship was one year. Then I purchased a practice right outside of fellowship in San Francisco, in the city.

Okay, so you had a pain practice. And it was integrative. There was already a PT. They were already two pain psychs. It was the reason I gravitated towards that practice.

Plus, it a high-volume neuromodulation practice, meaning a lot of intrathecal drug delivery systems, pain pumps, and neuromegulator stimulators.

Early life, medicine, and military training

And Stanford was not known for and is not know for heavy surgical. And again, I love the procedures. I loved the surgical, the advanced cases. And I knew that the retiring physician and the transition would train me in the operating room so that I could build up those skills while also learning the side of medicine of taking over a practice and growing.

So that's when I first started seeing volume issues. That's right. When I started first seeing the billing side things and that when is like, wow, this is not what I want to do ultimately.

What year was that? 2012 to 2014. Okay. And then you came here and you were working in the system and after a year you're like… That's when I was with the big group.

Yeah. That transition of, wow, this is not what's best for patients. This is NOT integrative. No. It's not the kind of system that I want to practice in and I'd rather leave than stay in any form of medicine.

What did you think you were losing inside of you when you are in the system? What was dying inside you? was gone. Having the ability to use my clinical judgment as the expert, as one who has trained so hard and who is seen so many wonderful things happen when you can work with patients the way they deserve to in an integrative approach, was going.

And it was turned into instead chart, chart chart. Don't sleep. Chart some more. and you're going to owe us some money. Yeah, that's just crazy. All right, so let's go to the opening.

So you started very lean. Did you start taking insurance at all or was it straight cash? No, 100% cash from the very beginning. Why? I'm with you. People will ask me sometimes, right?

And I'll be like, I have to sense how the person Because for some people, it's a security blanket. And I will tell them like, you can take insurance, just let's be really clear about what this is, right?

This is nothing more than a secure blanket because you're not going to get a better patient by taking insurance for the office visit because now they're conditioned to expect everything else is going be covered by insurance.

You're creating a hurdle where they have to reach into their pocket and give you money, but there's lot of doctors that They have that security of like, oh, I just, it could be a lead gen.

But it's not, they're not the same mindset patients. They're the not same at all, and it is really an albatross around your neck that's dragging you to the bottom of the ocean.

I couldn't have said that better. It's like you read my mind on it. Yeah, you know, when I've been doing this 11 years, right? And when think about doctors as they leave, All the fear that they have is not real.

Like, what did you fear when you left, or did not have any fear? I was pretty secure in knowing that I would not lose my house, lose car, or lose license because I wasn't committing malpractice because i was missing something in these five-minute visits or somebody was going to overdose on the opioid prescriptions that i basically bartering for procedures.

I felt freer to be able to go back into anesthesia. When I had more control, I tell you when I work, how many shifts I can do, How many of these things, so that I could be building in the background.

So I really didn't fear those things. I mean, certainly when you start to wean down and the security blanket of the income goes down, if you've not built up a nice nest egg and have these backup funds, If you're not going to go the

loan route, the fear of failure can be real.

And I've failed, and I have risen. So it's just one of those things. I guess it depends upon your risk tolerance, but I don't think I'm a low risk-tolerance person.

It's just part of the deal, right? It is part the of deal. Yeah. And so is fear because and you'd be silly if you weren't thinking that this could fail or that I could run into some hurdles.

That's going into it with your eyes open, not with blinders on. You know, and I've been bankrupt, Right? And part it was the economy, like I had a real estate investment company, so like 85% of my friends went bankrupt.

So it's like we all, you know we're all kind of laughed about it. But the Once you go broke, you either get so safety security minded that you never take any risk, or you got to the other end and you're like, well, I've already been broke.

So I already had the cars repoed and the sheriff showed up at the house. How much worse can this get? I take for granted at 58 now, my ability to handle stress.

Like financial stress, growing a business, right? We're growing this business. Just because I've done it before doesn't mean that I don't, it's not like I got a truckload of money sitting out there somewhere, like you still run it lean.

And you're just like… All we got to do is get through today. That's all that really matters. Let's just get three today, tomorrow's got enough trouble of its own.

Like, can we pay the bills today? Let us do that. let us just pay bills we can today and tomorrow we will figure it out tomorrow. And I think that creates the thing is, if I could teach a doctor from a business standpoint to take their medical training and apply what they learned to dealing with traumatic stressful situations, and apply that to business and like it's you save lives.

This is just business. Like you know, you've resuscitated people, You've changed people's lives, or you have cardiac surgeon or whatever, your knee, whatever right?

You help people walk again. That's way more difficult than this. Just keep some perspective, right. How have you, because you're pretty level-headed. What's about you as things were challenging?

In the business? Yeah, no, in the businesses. I'm sorry. In business. Thank you. Sure. Well, it's not my saying, but I do remind myself this is not med school hard.

Yeah. Right. So, you partner with people that are your mentors. You surround yourself with the people who are the experts in things that you are weak at.

If I am the stupidest one in a room, then I' m in right room. Right. How many people have said that? And I actually, I think in business or you're doing something that is totally foreign to you or very fairly foreign, that surrounding yourself with people that know what you need to know is the way to go.

Yeah. Who mentored you in the Regen space? Who were the people who stood out to from the medical side? I think it's more the institutions having the backdrop of TOBY, the back drop of IOF, those things where you could get around like-minded people from actually all over the world, not simply within the United States and you can learn from people that are doing it so many different kind of ways and in other systems that that had a bigger impact than, say, one person in general.

I mean, certainly there are some, I would go back to fellowship and say okay, this was an entrepreneurial attending. There were very few, most of them were within the academic system, but there were some visiting professors who would, not visiting per se, they were doing their own thing.

They were in Silicon Valley, building other things, so kind of bending their ear on something like that. specifically as a woman in business, being surrounded by other successful women in businesses has been very empowering and helpful to just kind of know.

Was that hard to find other women that were willing to open up? Sometimes there is a group, you know, wow, I think it's called Women in Orthobiology. Yeah, great group.

So that has been really refreshing to know that we can share protocols or share how did you get over this HR concern or how do you deal with whatever it is.

It's nice that it not this competitive thing or this I'm not going to tell you because you're going take it and steal it. you know, get so much further ahead of me.

I don't find that that's really in this space. Yeah, that, you I find the friends that I have, women entrepreneurs, and the funny thing is like 40% of my client base are women, like, which is significantly higher than the number of women in the medical field.

Like it's 40 to 50% at least. But the thing that i've always found fascinating is Guys, male entrepreneurs are much more open to share. And when I communicate with female entrepreneurs, they say it's even harder because it is almost like women don't have a lot of sharing, a heart to sharing.

Women entrepreneurs. But you didn't find that. You found that women have been the Marianne Bucks of the world or the Ariana Demers, people in WOW, like they've been very open.

To share in insights. In general, yeah. I think that you find this camaraderie and you say that we are a, you know, sisterhood because there can be fewer women in medicine, fewer woman in a surgical subspecialty such as anesthesia, et cetera.

So to find somebody that's like-minded and is rowing in their own boat but you're on the same path is refreshing and it's just a little bit grounding and I've really not found that.

Yeah, that is good. Because I thing, the industry needs it. You know where I stand on a lot of things. we have to get more doctors free. We have too. There's just, I just had three doctors at my house on Saturday for what we call one day.

Coming to my home, we'll spend a day together, walk you through the systems, you know, buy you lunch, go out to a really nice dinner. Obviously there's an opportunity to sign up.

And there was a doctor there, 59 years old, local community, family doctor for 35 years and he's like, I've been losing money for the last five years, like you've got to get me out.

Like, I got all these tools, what do I do? Another one who has, who's in pain and goes, yeah, the personal injury stuff is great, making really good money on it.

He said, but it keeps reducing every year and I see what's happening in other states. I know it's just a matter of time. You know, client's going to go from $85,000 for what we make in a case or something like that to 8,500, they see it happening.

It's, What would you tell a doctor who's in med school right now? What you would tell them to do when they come out, meaning not specialty? Would you encourage them go out on their own?

What advice would you give them? Start your brand right now. Get your own domain right, now, yourname.com. Start building your presence now and that's not going to be anything that is usurping what's going on in whatever residency you fill in.

Be mindful of HIPAA. But start building you brand now go out on your own. You do not have to follow suit with the things that in your residency you're only seeing those kind of things.

And I'm trying to make a change in that with presentations at ARMA for we had a spring training and really it was for residents in the anesthesia department, and it's like there are options other than academic.

So, we had on the panel, private practice, hybrids, academics. We had all these different options and if you don't hear about it early, if the residency programs don t allow you to rotate in electives early Right?

Come rotate with me, come rotate. So I think it would be know that there are ways out and that you can see what's happening around you. This generation is coming out saying, I'm not even sure I even want to practice medicine.

Do I want even to finish getting my degree? Therefore, yes, and start building your brand because you may not be the best consultant straight out of medical school, but you can start working with and engaging with MedTech and other companies and bringing, I guess I would call it, legitimacy to everything that you see on social.

You should be the voice of authority. Right. That is saying, this is what's about peptides. This is about the intermittent fasting. Name your passion.

Mm-hmm. not somebody that doesn't even have a degree or if they do, it's certainly not in medicine and doesn' have all the anatomy, physiology and all of that background.

So start from day one, even in medical school, you can start building your brand. Is that how you've built your practice? How have you grown your, what's the name of your practiced, by the way?

Precision Regenerative Medicine. And it is located in North Scottsdale? It is. Okay. What are you focusing on? Are you mostly spine? I am spine and joint.

I do not focus on wrist and hand or ankle and foot, but everything, major joints and spine, I'd say it's about 50-50, joints in spine. But it is more of a whole system approach.

It's a constructive, regenerative medicine approach Okay, so tell me about that. What does that mean? It means that traditional pain and even some of these traditional ortho, orthospine, neuro-spine anybody who's doing these kind of procedures is destructive.

From pain practice to regenerative medicine

Anytime you use a steroid it's destructive, it may be a temporary band-aid but we have numerous studies that show that cartilage acceleration into osteoarthritis is faster.

The idea that you can rupture a tendon from repeated injections faster. All these things, it's destructive. And when we destroy the medial branch nerves that go to the facet joints in the spine, which are kind of little tiny guys that help here, and that's that bending, twisting, extending motion, that Home Depot belt across the low back or across-the-neck pain, that those nerves also go to the stabilizing muscles of the spine and you're destabilizing, therefore accelerating in the case of spine to fusion, accelerating, in case, of joint to total joint arthroplasty.

So destructive, not about that at all. It's constructive. Think about anything that would build. Well, then you've got to step back and say osteopathic principles structure and function, you've got to look at the way the body's moving.

If we've flat feet, we're going to put an undue amount of stress on typically the medial aspect of the knee. We've gotta work on that. So from the ground up, the whole kinetic chain.

There's that, there's diet, hormones, how are you nourishing this body with regard to sleep and stress reduction and the mind-body connection. That's constructive.

That's before we even put a needle in. Are you running full blood panels on people and putting them on hormones before they do treatment? I'm not typically doing the hormones myself because that is an expert level above and beyond where I want to focus.

I am an experts in other things, so that's where will likely partner with somebody who's fantastic at, particularly in the men's space. baseline labs and depending on the person that baseline panel will differ.

Are we going into the fasting insulin because there is absolutely screaming your insulin resistant labs or is it more of it's a healthy athlete who just keeps getting re-injured and we've got to do kind of some of the basics but absolutely metabolic health and I include hormonal health as part of that is vital otherwise we're taking inflamed blood putting into an inflating joint and rolling the dice on whether or not we're going to get any benefit from all this hard work and investment.

To me, that's the future. Those two areas are merging. They have to merge. There's a couple of reasons. One, it's the best thing for the patient without a doubt, right?

Like we noticed this at the ED clinics. We were the pioneers of using PRP for erectile dysfunction, venous leakage, and peronies. A lot of clients with perones, the scar tissue with the unnatural bend.

So what we notice is that we had this, we have some patients that came to us and then we put them on hormones, right? And this was basic, like, this is basic cypionate or pellets.

Like there was no, there were no peptides. There was nothing, we had no semaglutide or anything like that. But what we started noticing is the guys that would be on the hormones and if they were on their hormones for at least two weeks prior to doing their PRP injection, We started to notice that they are getting better, faster outcomes.

So my Dr. Gibbons came in and he said, you need to take a look at this. I'm like, so I know it's anecdotal, right? Like, this is not a double-ply study.

And I was like huh. He's like I think we need a change the protocol. Okay, let's do it. Change the our improvements went through the roof. And that was the first time, this was 2015, 2016. I mean, who knows how many billions of cell, like we had the Magellan, so I'm assuming we were getting a good cell count.

We didn't have it, we weren't counting, We were just pulling blood and injecting back in. But you started to see this, and that is where the light bulb went off in my head.

If we did this full scale, and what we know now about the whole functional health space, do you know Dr. Shakthar Shastra? You know Shak? I do. He's doing this at a big scale.

Like he just spoke at the BHRT Training Academy cruise symposium at sea. His numbers are insane. Great. And people are spending money. They're like, get me fixed.

And I'm glad to hear you're doing that. Now, are you doing anything like HBOT or laser shockwave pre-post, anything that? I have not added in HbOT. I don't have chambers.

It's an expensive thing. Get a referral partner. Exactly. That's what that's about. Similar with Red Light, the lady that I space with has entire red light room, we can bring in before doing the PRP and we do the high intensity interval training with red lights on, then we draw the blood.

We were doing little things like that, but where I'm more likely to use the adjunctive is in the in-season athlete or say you're getting ready to do a charity golf tournament.

Right. And it's not the right time to inject your elbow right now because it your dominant arm and you are going to feel it. So what can we do to get you ready and to palliate and get space for, but there's still regeneration going on prior to the actual using of your own cells.

That's all part of prehab. Okay. Are you Are you doing multiple PRP injections for a joint, depending on, or are you a one and done person? What's your philosophy on that?

what do you feel is the right approach? I personally have had great success with one. We certainly reevaluate. Oh, yeah. You know, it determines whether or not we're going to do a booster, but that booster is not at six weeks, It's not eight weeks.

It is at ten weeks and it may not even be until four months out. Because we are still on that trajectory. Where did we get versus where do you want to go?

Did I get you 80% better and it's realistic that we can get another 10%? did I give you 50% and you'd be settled with 70? What happened in that post injection time frame?

Were you able to maintain the rules? Right? Were you immediately back to sport or did you go on, you know, a trip to Amsterdam for two weeks and all the alcohol, right?

Smoking weed. Yeah, walking around. So what was it about? And each individual, but I found that if you do it right the first time and you the baseline platelets and what your system gets and know what you're delivering precisely with ultrasound and or fluoro-guidance every single time, that you can do really well with one injection.

Are you testing cell counts on every patient? I am testing self-counts on my new patient. If it's a secondary follow-up, I'm not likely to. On my stem cell ones, bone marrow aspirin, 100% across the board since the very beginning.

And that's an investment in and of itself, but it is worth it to me to have that kind of data. You know, that was the thing that I remember about when we worked together, is that you were one of the first that i was really exposed to that, was doing that kind of detailed work.

But that early on, like it was like 1920 or something, 2020 or, something like that. That's my quality assurance. Yeah, and that's, I was, oh yeah, yeah that makes sense, you know.

Like nobody was that doing. How are you getting patients? How do you market you and your facility? What do What works? What do you think works?" I think having very good relationship with your patients, and they are the ones that tell.

It's that organic. I ask everybody how they found me. Everybody. And I'm the one answering the phone, so I know. Right? And they fill it out on the form.

But there's some Google. So having a very strong online presence is critical. Owning yourself, your website, you're Google business profile, everything that is out there on you.

I Google myself regularly or I'll ask the LLMs regularly, who is the best, and if I'm not showing up, then I've got some work to do. And I want AI to say Dr.

Tammy Penhollow, Precision Regenerative Medicine, and I worked very hard for that. But most of it is my sister came to you, or my uncle, my doctor said that you're the best.

Do you have a specific process to make sure that those happen? Do ask them for referrals? Anything in particular that your doing? I do ask, it's a little bit hard, people are a bit shy even to leave a review.

Yeah. I try to make it as easy as possible to a leave review, a QR code they can scan, those things. It's really hard. If we could just help one person just like you.

It would mean the world to me. One person. So you think one person, I can think of one, person to tell about you. Yeah. Make it actionable, make it small, not like, hey, tell all your friends and family, that's too vague.

Being very intentionable, intentioned about who you ask and what you asked them to do, the timing of it, right after you put a needle in them and they're aching.

They just did their album and like that really hurts. Exactly. Or they're coming out of the MKO melt from the back part procedure. Not the right time.

It's a good time, but it's not the time right. Christine's mom just had her hip and knee done. She went to go see Donnie. And I was like, how was it, Diane?

She goes, man, those MKL melts are fantastic. I'm like yeah, they are. If you try them, I'd have heard about them. A bunch of us are like you know, maybe we should just get them and I'll get a room and take some MKM melts and have a fun hour or something like that.

Who would have to document that? Yeah, I know. And then I'm like, yeah, well, maybe that would be against the laws. Maybe we shouldn't do that. It's like all right, we'll stick to something else.

We'll go to Denver and do ketamine or something like that So do you do like any webinars or like live events? Or is it all just word of mouth is how you're growing?

I had done webinars. I didn't see a lot of bang for that. Um, I have gone live on YouTube a few times and I try to stay involved in the community. There's The Women 360, which is a very large networking group throughout this whole Phoenix metro area.

And there was a March to Wellness event live and purchased a booth and was on stage. So those kind of, you know, Well, you've been speaking a lot more, haven't you?

You've intentional. I know you have been at the conferences. You have spoken a couple of times, right? I'm very intentional about that. Yep. Um, I don't tend to turn down the invitation if that's a possibility.

And some of them are even webinars for the AOM, those things that are just educating physicians. So part of it is how many people can I reach versus how people we collectively reach if I train.

the physicians in the benefit of prehabilitation the importance of the functional spinal unit the Importance of The functional elbow or the function only name that joint unit rather than just intraarticular and done Yeah, right Then we're gonna give the whole practice of regenerative medicine a better name because as you and I mentioned before we even started this is the wild wild west Yeah, maybe it's only one wild.

Okay. Maybe we've dropped one of the wilds. It's not too wild wild, and maybe just wild But every day gets a little bit more, you know, it''s like every you see it getting a bit tighter and a But there's a lot of renegades out there.

You've been pretty active on social media on LinkedIn about calling out some of the renegades. I still get phone calls from patients that had a mother calling on, or excuse me, a daughter calling, on behalf of her 90-year-old mother.

and talking about how, well, we talked to this guy and he said that if we did IV exosomes that her brain fog would go away and we've even got evidence against the dementia she has.

Wouldn't it be fantastic? Why would you want to draw her blood and do things like this? If we can't just use exasomes in the IV. Like, oh my God. Because they're dead.

Oh my god. Yeah. But that's happening. So it is wild, wild from the stories I'm hearing. What concerns you the most about that? About those fringe companies out there making wild claims.

Aside from the true patient safety issues like blindness, death, and substance? Yeah, aside from those. Okay. Yeah aside for those minor ones. aside From death?

Aside, from death. Hey, you know, it's all gonna happen. What do you worry about? The erosion of trust already coming out of the pandemic and you look at poll after poll and the erosion the patient-doctor relationship, the feeling of trusted within the medical community and that that's what so many people say that drives them to the Jimbrows, that what drives to them the Quack Clinics.

and the scam cell clinics on the corner and all those things that are not legit. So I think the bad actors out there can really What do you say as a coach that one bad review, how many good reviews do have to?

Oh, you mean 10 to 12. You can have 55 star reviews and you get one person who just has a vendetta and they'll give you one star and people will focus on that.

Okay. Similarly to this. One bad scam cell clinic takes how much legit operators who are practicing ethical regenerative medicine to outweigh that? So how do we stop it?

How do get our arms around it. Outcomes, data, publishing, those kind of things are going to be important to those who want to say, look, we've got, and here I have a little bit of a problem with academia.

There's only so many double-blinded, randomized, controlled trials that you can do when People are people.

Constructive care, PRP, and data-driven outcomes

You cannot control for all the variables. Absolutely cannot. So you're never ever going to be able to say, don't eat your protein. Don't take your creatine.

Right? Don't let your blood pressure get out of control, but I don't care if it's a little bit whack, because that's the only thing we're controlling for right now.

We're control for how did you do with PRP in your left knee? Right. Right, we are never going to be able to do that, so I'm not sure that I can put all of my eggs in the, there's got to more studies.

I do like the patient reported outcomes and the outcomes databases, I think that gives us a lot of credence. like data biologics or who do you… I personally do not.

I collect my own. You have your own data. Okay. And then do share that data with patients? I do. Yeah. It's a really powerful tool. In this, I'm not pimping for data, biologic.

We're friends, right? But we have clients that will take the printouts and show this to the patients and they're like, bam, it moves the needle so fast.

Well, if you can say people like you, Yes. It needs to be a 55-year-old golfer with elbow pain that is not morbidly obese, is I know you, Gal. You've told me you're eight versus comparing it to an 18-year-old who's being scouted for a Division I and they've got a rotator cuff tear or a labral tear.

I can't show 50. X year old male to an 18 year-old female swimmer, totally different. So to be able to do that, that's where I do see the benefit of a large database and paying extra within that construct to compare yourself to the others within.

Yes, so that is one way to maybe earn back some of that trust because trust has been eroded. What's your feeling on some of the changes that have been coming from HHS, from Health and Human Services, peptides?

It's a big broad topic. It really is. But what's you're feeling in that? My feeling is that the possible benefit of, let's just say, July and having a certain number of peptides come off of the no-go list and potentially be able to be compounded by reputable 503A compounding pharmacies that it takes things out of the gray market.

The gray-market is where I'm concerned that people are using for investigational use only things. You have no idea

how sterile that is, if it's actually what it says it is.

And you have not oversight over what if there was a fungus that was then replicated or a, name that, endotoxin, bacteria, whatever it, is that right now it truly garage-level gym bro stuff that we really don't know what's being injected and the safety concerns are mine, yet I've read arguments that say, well, physicians aren't doing anything about it.

So I'm just going to get it the way I want, and I am not even going tell my physician what I use. So then I wonder, are they telling me what they're using?

And if we get an untoward effect from what we're working together, was it undisclosed use of something that was for investigational use only, or for animal use, only?

Or was something truly happened in your own physiology? I was at a party in LA a couple weeks ago. pretty high, higher end, right? A friend of mine there is there invited me, he's my doctor, surgeon.

And we're hanging out and people are asking what I do, you know, I work with doctors, anti-aging, longevity, regent, and I must have had five people say, can you give me peptides?

I'm like, I know, I can put you in contact with the doctor. No, no, like I just need like some BPC 157. It's almost like it's become like the designer drug.

Right. You know? No. it works. I mean, they take it every day. mean I take a lot of peptides, right? I, mean testimolar and you know I do all those things.

But they're all, you, know clean reputable like you. Know I. Mean, but then talking to this guy goes, Oh, i can get you peptide. So I got to go overseas.

He goes let me give you his number. Here's his WhatsApp. And I'm like, You're going to buy. Peptides from somebody's whatsapp number. Well, you know like how bad can they be?

I'm like they could be really bad like Please go call talk to this doctor, please Go go talk, to somebody who's gonna do this the right way like right now is there a right?

Way is our illegal right, way for those that are on that no-go list Well a technic, well i'm not a lawyer thank, god and i got a d and contract law so um i I feel pretty confident that there are a number of reputable compounding pharmacies, not the small ones, the big ones that are producing this, that I'm pretty, and my doctors that we work with are using them and recommending them, prescribing them that they're going to be clean and they are going be good.

Is it legal? Technically, probably not. And yet, I have seen the results in me. And I know what it can do for humankind. And then I always ask myself, is it worth it to be the trailblazer?

Right. I don't have the answer for that, Tammy. Like I'm, I, don' t have a medical license. I don''t own a pharmacy. As Brigham Bueller said, you're in the perfect position.

He goes, they can't come and investigate your pharmacy like they came with me. They can' d threaten to take your license, right? Here's what I I see I'm going to use my own body as, cause you knew me six years ago as much heavier, right?

With the use of these, I mean the best metabolic health at the age of 58 that I've ever been in my life. So why not? I would like more data in humans.

And I respect that. I'd like to have a mechanism of action of each of these inhumans. Some of them just not sure that we do. I'm data driven. Yeah. And I am safety.

I mean, anesthesiologist, I, am your primary safety officer, right? You are paid to keep them alive. Right. So that's a big deal to me and my medical license is quite valuable.

Mm hmm. Um, encouraged. That at least the conversation is happening. You know, um, because they're inexpensive, they are cheap. Really? Yeah, the cost of them are All of our clients, we teach them, you put it into a package, so it's overall.

It's not the cost of the medication that's getting marked up, it is the wisdom to apply it, right? That's really what it. But I think some of these things like thymus and alpha and testimoral and BPC 157 and all of this can have really great positive impact on people.

I mean, I can tell you my own injuries that I've had of injecting BPC-157 as I have an injured shoulder in my delt, and I get markedly better faster. I think there's great potential with these things.

Yeah. And I really do. Any time we can move control of care from the pharmaceutical and health insurance companies back into the hands of the doctors, in That should be a decision purely between the doctor and the patient.

And the doctors should have the time to talk to the patients about the options. Absolutely. and educate them. You can't do that in seven minutes, can you?

No. You can only say, I'll see you in 60 weeks. And then you get another seven minutes. So I'm encouraged. I am encouraged about what, you know, Secretary Kennedy is obviously a controversial person, right?

But I've encouraged, that I like the fact that we're actually finally having the conversation versus in other administrations, it was just straight demonization.

Because I think that there's a lot of other things out there that could help benefit the human race. Agreed. You know? And I should be exploring all of them.

And as Donnie said, we shouldn't have to spend a million dollars to go through an FDA trial. It's crazy. Agree. I keeps all the little guys out where all innovation happens.

So I'm all about pushing, let's see what we can come up with. We're just scratching the surface. Every time I send somebody to go get a regenerative therapy procedure, like I said, we sent Christine's mom.

And now her dad just called me this morning. He goes, I'm going to get my shoulder and knee done. What do you think? I was like, it's about damn time, Bill.

Like, go for it. You know, you're going feel much better. Therapy isn't working. Shit. Right. So, when we were talking before the cameras were rolling, I wanna dive into this because you had some pretty, and I want you to let it fly.

We're talking about bolt-on services and bolt on businesses. Tell me what you meant by that. What do you mean? And what's, cause that's something that you have a pretty strong opinion about.

similar to the Wild West aspect of things, where you maybe have people that aren't fully trained doing these kind of procedures that should be done. I think that's not great.

It's great for patients, or they're doing them without image guidance, 100% no-go or whatever, right? Oh, God, yes. Yeah, people doing without the image guide should Are you talking about like the orthopedic surgeon that's read this that are only doing eight cc's or ten ccs and not yeah, so so I mean First of all, let me say I have compassion for the physicians that we want.

Yes collectively to break away and leave the system and gain their autonomy and truly help their patients. I

absolutely feel for that, that the insurance companies are taking more and more in every single year where your reimbursements go down.

Granted, I'm giving you all of that. However, one of the things I see marketed to physicians in insurance-based practices is add region, add this cache base, it could be a laser, a shockwave, PRP, whatever, but when we're talking about regenerative medicine and it's actually harnessing the body's own cells to take that and bolt it on, to your insurance-based practice without understanding the systems-level changes that need to occur and the mindset shift that needs to in you.

It is a paradigm. Yes. I'm still going to inject with cortisone, and if that doesn't work, let's go PRP the next week. Or I'm going to take the very first rep that comes to me and says, oh, well, I am an orthosurgeon and I happen to use this brand and the OR of this implant.

And they also happen have a centrifuge and a PRP kit that is, let's just say, like doing plasma instead of doing platelet rich plasma at best. Maybe getting a billion cells at best, maybe.

Maybe. Yeah. So that is a shift in the system and it's the antithesis of the constructive approach. It's still that I'm praying that i can keep the doors open, we're going to add some cash-based services, and this is the way to do it, it might be my little flight line, my thing that's pulling me up.

It's not the same. And I would say, please, get educated. Change the whole thing. If that means you've got to transition from 100% insurance-based to hybrid and drop, drop like you teach.

That's a whole different story, Matt, but it's not the same as, well, we just need some cash-based stuff because the guys that are running the numbers say, it is going down, what are we going to do?

And you have not made that shift in your mind that is 100% patient-centric. That is not why you are doing it. You are not adding a cash based service so that you can help patients.

That's what bolt-on is so the thing I noticed and you know, we talked to 20 doctors a month on the phone, right? You know deciding whether they're gonna come work with us most of them if they have cash services Maybe $5,000 a month on the top end, $10,00 a months.

And you mentioned something is they haven't made the shift in the mind. So what happens when you're struggling psychologically, when people are struggling financially, they actually start grasping at straws instead of doubling down on what they know, okay?

And so they start looking for quick fixes. It's like the heroin addict who, you know will inject anything because they can't get their fix, right? And so what happens is that they have a lot of these incomplete things.

I've got this over here. They're looking for the tactic to save them versus going through the transformation to become the person, the future self that need to come.

Exactly. And you said something beautifully, is you've gotta have that mindset. You have to, when we can get a client focused on their future self in calling that future into them, not chasing the future, but calling the feature self into that.

We talk about the quantum field. Pulling that person from the Quantum field, your future self, and acting and operating the way that they do, then that transformation happens like that.

Like within 90 days, we'll see like a massive change in the person first, than the business. People expect the Business to change, which then will change them.

You have to Change yourself first. And it starts with that future Self. So I love what you said, like the bolt on from a concept of if I'm going to use this as a transition is one thing.

But the bolt, what you're saying, if I understand this correctly, the bulletin is the savior is not, you don't like that approach. You don' want to see the bull town as the quick fix savior.

Because it's not going to, your practicing crappy regenerative medicine. It's no regenerated medicine, no, You are adding a cash based service to your practice and you are giving the entire field a bad name.

Peptides, stem cells, and the future of the field

Mm-hmm. Yeah, anybody out there who's listening this, if you're injecting without ultrasound guidance, you need to call Colin Rigney and Ryan Martin and get trained, because like you are doing a disservice to the industry.

Right. Absolutely. And if don't know what your cell count is, for the love of God, just get a machine that proves it to you that the cell is right. Get a counter for whatever…

Send off specimens, right? Just whatever. You don' have the ability to do the QA on the machine every day. Anytime I see Donnie, I love it when you post those studies of like, here's a study in the American Medical Association Journal about how PRP doesn't work.

And he's like you can tell on the first two paragraphs, they didn't know what they were doing. They pulled 10 CCs out. Like what do you expect? Right.

I loved those. I love when he breaks it down and just eviscerates somebody. What do feel, so you've been on your own since 18, 2018, eight years. And you've been in the industry, obviously, for that long.

Plus, what do you see coming on the horizon? What are the things that excite you about some of the thing that you that have promise? I understand the study is under 100%. But when you look at the initial stuff, you get excited about.

What other treatment things do see you coming? – I'm excited by expanded cultured autologous cell therapy. – Okay, tell me about that. taking your own bone marrow or your adipose coming back a month or several weeks later based on whatever it is.

Fat takes longer to just isolate into and expand upon MSCs, mesenchymal stem cells. Bone marrow can be done in about a months. But bringing that to the US, not having to rely upon one industry, one group in Grand Cayman, which is a fantastic and totally legit facility.

But in terms of being able to bring it to the masses and bring on our shores would be ideal. I think it would decrease the number of medical tourists that are going to countries where the safety, again, is dubious.

Patients that then end up in ERs, patients that come back across the border and have to say, look at this massive infection, how can we fix this? So, I think that's exciting, although I'm not hanging my hat on that it's just the stem cell.

It's not just MSC. What do you think it is? I thinks it the whole enchilada when we talk about bone marrow, that there's the IRAP. There's all the other things within the bone-marrow plasma and the Bone Marrow Aspirate concentrate specifically because I double spin and concentrate.

That if I were to take head-to-head, I don't know what the number is going to be, Matt, but let me throw something out. Say 18 million stem cells in a vial of just stem cell fat.

What would it take to overcome what I can do with bone marrow? I'm thinking that you're missing a lot if you don't have all the other things that are in there.

And so some people who are using fat right now that is not expanded will add PRP because you've isolated the stem cells within the micronized adipose in fat.

And you add the PRP, so you've got the growth factors, anti-inflammatory cytokines, et cetera. So I'm excited about that aspect of it. And I think we are going to be able to overcome for things like age-related decline in stem cells.

It is going make your, my, prehab even more effective in terms of optimizing a patient beforehand, before the harvest. But then we're going to also have that option of expanding even above and beyond because there is a dose response curve.

So that's what really excites me. Okay. Anything else that is really exciting you? Oof. That's a big one. What is your medical feeling some of the states have been approving and saying like Utah and Tennessee and Florida have saying, hey, umbilical cord is fine to use.

What's your feeling on that medically? Well, I don't think there's any data right now that shows that those cells in terms of stem cells are alive. Right.

And when we have the ability to use our own stem cells from either bone marrow or adipose, I would rather use your own for several reasons. A, they're dead.

B… The umbilical cord. Yeah, yeah. They're death. And they are not always made in a CGMP facility. So again, one endotoxin, virus, bacteria, whatever multiplied and cultured.

It could be at worst, you get no benefit. At best, at best you're blind. You've got a massive infection. you've spent tens of thousands of dollars on something you got no benefits from or I think that there can be longer term ramifications.

It also hurts the field. Um, it makes sense to say, oh my gosh, wouldn't it be amazing to have day zero stem cells, but the process of preserving those or radiating those, thawing them, et cetera.

Dr. Centeno has done the work. Yeah. He's plated these things. I have seen no appreciable stem cell on those plates and I don't think he's making this up.

This man is a consummate. physician and scientist. So I don't really see a benefit of that. I understand right to try when we're talking about something that is truly life-saving, like I've got stage four cancer, I want a right-to-try, something is going to potentially give me more time with my family.

This is not that situation. I understand osteoarthritis can be devastating. Back pain can't be devastated. And I'm not negating that, but this is one of those situations where it's a compassionate use.

So I do have some issue with that. You think they're pushing that so that then they can get those things approved for the health insurance companies and it becomes a financial boom for supplier of this?

I don't know. That's usually the path. But then you have to look at it as a doctor who's maybe thinking, oh my gosh, I can do it. It's so easy just to get a vial inject and vile.

We're not going through the hassle of liposuction or bone marrow harvest, et cetera. Tell me, how does that work out for you when you were getting $1,200 to do a mild procedure and now you're getting 12? Right.

When I was getting paid… Look, it's not a benefit for the doctors. It's a benefits for pharmaceutical companies. But doctors who are doing it thinking that it is fantastic for patients might see that right now I can get a margin of X on a vial of Y.

If that does go through and the middlemen do become involved, then it does become this health insurance related thing. That's why I'm not a fan of PRP, bone marrow, or micronized adipose ever becoming covered.

Oh, God. No, I'll fight that to the last. Because, right, you're going to get paid $2.50 to do something that costs you literally your time, all the risk all the, not to mention her loss.

They'll tell you you can't pull 60 cc's or 120 ccs or do a double spin. The concentration will be wrong. You'll just, they'll be like, no, let's, and then there won't be any benefit.

No. So I don't agree with the same argument when we're talking about birth tissues. Yes. Yeah. the thing for me, I get asked this a lot, right? A ton.

Again, same party, Right? And I'm standing, who's actually in this guy's yacht. We're standing on this, which was really nice. LA. And so we're standing up in the third level and he's taking us out through the harbor and we are standing there and talking to some folks and this guy's like, yeah, you know, I just had, umbilical cord injected into my knee and da, da da.

So how much did you pay? I forget the number. I said, why didn't you look at doing your own? He goes, oh, well, because I'm older, my stem cells are not as vibrant.

You know those stem cell were dead that they injected in you? I go, for less than that cost, what are a doctor's charges? On par, that's less expensive for you to harvest your own, and we know for a fact that it works better.

I've never seen any study that animal, umbilical, any of that performs better than my own. And I won't say that I read the studies in detail, like you would, right?

And, I get a lot of my studies from talking to doctors, but I have never one study even gets remotely close. Anecdotal, data biologics, You know, whatever.

I've never seen it. It's such a sales job. it really pisses me off. So can we call it wild wild again? I can call a fraud. How about we called it fraud?

Okay. Okay, it's it it charlatan stuff. Yeah, I mean I get phone calls. Hey, we want to introduce you to you know my doctor. Your doctor's gonna love this.

Here's here's a doctor who's doing great. And like just get away from me like one I don't do that to my doctors. That's not my job to No, no, it's just I find that stuff so bad.

It's really stunning to me. What is, for you, what does your future look like? What do you see on the horizon for your practice and for growth? Continuing to help patients in clinic, certainly, taking them on that constructive journey and changing their lives, but also on a larger scale.

As I said before, when I teach physicians, their patients are impacted. We can make a large reach at that point. Your goal is to save how many doctors?

100,000. Okay. So that's fantastic because then you extrapolate and say each one of those doctors can affect this many patients. We can effect 40 trillion dollars in healthcare savings in the United States alone.

Okay, I don't have that, those numbers for what I… It's in the book, it's chapter 13 in a book. You can read it. Now, they're soft numbers, okay? Like, let's, you know, but if you look at how much money you save, and it takes 18 months for somebody to go through like the prep for a hip replacement, in wasted time with work and energy and all that and the drugs and that.

Like and then if look, at saying spending $12,000 if they were to do a high level BMAC, if needed that right? With some hormones or BP, whatever. It's about $12,000, right, on average.

Some of them might be a little higher, some might a bit lower. The cost is $48,00 if you go down the traditional path of what the patient's going to pay out of pocket.

Okay? Right. I mean, that means we're saving $36, 000 per patient. We get 100, 00 doctors serving 1, 0 patients, I think is what math is. You get to Fort Tronium pretty quickly.

you do. It doesn't take very long. we can save… I believe the future of our country There's a lot of issues in every country. I believe the future of our country is fully based on our ability to fix our metabolic health issues and the way that we treat patients.

Yeah. We've done more harm since 1986 than times 10 than all the rest of the years combined, which includes the people that used to think that leeches were a good way to heal people.

Right. from practice, understanding the body in medicine and we understand it, we know how it works. We're so far from the application, the ethical application of that because everything is about money.

Everything. Look, I'm all for doctors charging what they're worth, right? It's one of my core tenets. But at least it's going into their pocket and it is helping the patient.

versus going into some politician's pack. I just looked up the numbers. $86 million to the top 20 people in the United States Senate. How many people could we help with that?

$ 86 million, to prove their point that they're right. So frustrates me. It pisses me off to no end. So when people have authority, when they are the expert, then using that for good is a calling.

And that's one of my callings. To educate as many as I can and whether that be, well it will be. Patience. Obviously it'll be other physicians trying to leave the system or who have left the systems and want to find the way.

a very structured way that they can incorporate it into their practice. They don't have to do what I did where you reinvent the wheel over and over again.

You can take something that is proven and something has results and you can apply it and your impact then is magnified. Yeah. Imagine, you know, Scottsville has a lot of retirees, right?

Phoenix. Um, imagine. 80% of the joint replacement surgeries are deferred for 5 to 10 years because of regenerative therapies. Or 15 in the case of knee.

Yeah, 15 is in a knee? That's the data from Dr. Hernegut on the intraosseous femur. What's that? I don't have that data. Okay, that's fascinating. 15 years.

One knee replaced, one knee bone marrow, a 15-year follow-out. I was having dinner, I have a college buddy of mine that lives here in town, and I had dinner with he and his wife and we were in old town.

Then we're doing like a wine thing, right? We were going from, so we we are walking, Right? Sure. And she's like, this was right around November. I think it was around Thanksgiving.

She's, like oh yeah, by the way I'm going to get a hip replacement. I'm like, what do you mean you're going to get a hip replacement? We're walking. There's no limp, like nothing.

And I go, wh-what do mean, you going get hip replacements? She goes, yeah, I went and saw the orthopedic surgeon. He says I need a new hip, so they're gonna get me before the end of the year.

Did they do an MRI? And she's like no. They didn't do a MRI. No. X-ray? Nope. Ultrasound? No You just went in and you saw an orthopaedic and they said, You need hip-replacement?

You don't need one." She's like, I'm not a doctor, you know that. You won't one. Walk fine. Go call, and I said, call Osh, right? And I texted him, she went and had it done.

And he gets the MRI done on her and he's, like you don' need hip replacement surgery. All I could think of is that orthopedic surgeon was trying to make their RP use.

trying to make their bonus by the end of the year. She's like, well, we went to the largest group, da da, and I'm like that pisses me off. That piss is me often no end because there's so many surgeries, hip replacement, knee replacement shoulder tons of them to me that don't need to be done.

It could be safe. at least postpone for quite some period of time and how much more activity do you have during that time frame and you're getting healthier through the system all the while.

And you may even get to a point where you don't even have the inflammation in that knee. I consider it a success, for example, if a woman comes to me and she's every joint aches.

And she's not hiking, she is not doing the things she wants to do, her shoulders, you can't play pickleball. She's in florid menopause. We correct the hormones, we get her eating anti-inflammatory, She is now sleeping better, nothing hurts, thanks.

That's okay, that's fantastic because look what we just did. You're a healthier being for even have met me. Yeah. Well, and, you know, the anti-inflammatory diets that they get put on, do you use that as well?

Absolutely. Yeah, it's so powerful. It is. So, anything else you want to share, Tammy? Anything else that's on your heart and mind? Not really. You sure?

Yeah! Okay. Thank you for coming in. My pleasure, thank you. Um, It's always great to connect with you, are you going to be at Toby and IOF? If this episode got you thinking differently, hit follow and share it with someone stuck in the system.

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